Transitions 2002

A 5-YEAR INITIATIVE TO RESTRUCTURE INDIAN HEALTH

Prepared by
The Restructuring Initiative Workgroup
For The Indian Health Service

June 5, 2002

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Submitted to

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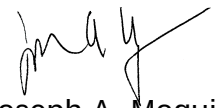
A LETTER FROM THE CO-CHAIRS

As co-chairs for the Transitions 2002 Restructuring Initiative Workgroup, we thank the Indian Health Service (IHS) for ensuring the voice of American Indian and Alaska Native people is heard in designing and restructuring the health care delivery system that serves them.

American Indian and Alaska Native people make up the diverse cultures that existed on this continent long before Europeans arrived here five centuries ago. When Europeans arrived in Indian Country, it was filled with people with long-standing governments, cultures, languages, and traditions. We existed as self-governing Tribal groups. Not only do we want to continue our existence as self-governing Tribal groups, we want to enhance our communities and the families that anchor them. We believe that the Workgroup recommendations proposed in this preliminary report will help do that.

When the IHS issues this report to the key stakeholders in Indian health, we hope you will respond with your feedback about the proposed recommendations. Your feedback will be reviewed and considered by the Workgroup before the final report is prepared. If you have any questions, please contact us or any of the Workgroup members.

On behalf of all the Workgroup members, we extend our appreciation to the people of Indian Country. Representing you was a great honor.



Joseph A. Moquino
Council Member, San Juan Pueblo
Tribal Co-Chair

Kathleen A. Annette, M.D.
Director, Bemidji Area IHS
Federal Co-Chair

Aberdeen Area Representative ***Phillip "Skip" Longie, Chairman*** *Sprint Lake Tribe* *P.O. Box 350* *Fort Totten, ND 58335* *(701) 766-4221* *Fax (701)766-4126*	*Navajo Area Representative :* ***Randall Morgan, Staff Assistant*** *Office of the Speaker* *The Navajo Nation* *P.O. Box 3390* *Window Rock, AZ 86515* *(928) 871-7160* *Fax (928) 871-7255* *randallmorgan@navajo.org*	*National Indian Health Board Representative:* ***Julia Davis*** *Nez Perce Tribal Council* *PO Box 305* *Lapwai, ID 83540* *(208) 843-2253* *Fax (208) 843-7354*
Alaska Area Representative: ***Paul Sherry, CEO*** *Alaska Native Tribal Health Consortium* *4141 Ambassador Drive* *Anchorage, AK 99508* *(907) 729-1900* *Fax (907) 729-1901* *psherry@anthc.org*	*Oklahoma Area Representative:* ***Jefferson Keel, Lt. Governor*** *Chickasaw Nation of Oklahoma* *P.O. Box 1548* *Ada, OK 74820* *(580) 436-2603* *Fax (580) 436-7209* *Lt.Gov@chickasaw.net*	*National Council of Urban Indian Health Representative:* ***Loren Sekayumptewa, Chief Executive Officer*** *3008 North 3rd Street* *Suite 310* *Phoenix, AZ 85012* *(602)279-5262 ext. 224* *Fax (602) 279-5390*
Albuquerque Area Representative ***Joseph A. Moquino, Council Member*** *San Juan Pueblo* *5300 Homestead Road NE* *Albuquerque, NM 87110* *(505) 248-4777* *Fax (505) 248-4115* *jmoquino@abq.ihs.gov*	*Phoenix Area Representative:* ***Velasquez Sneezy, Vice Chairman*** *San Carlos Apache Tribe* *PO Box "O"* *San Carlos, AZ 85550* *(928) 475-2361* *Fax (928) 475-2261* *VWsneezy@theriver.com*	*Federal Representative:* ***Dr. Kathleen Annette, Area Director*** *Bemidji Area IHS* *522 Minnesota Avenue* *Bemidji, MN 56601* *(218) 444-0451* *Fax (218) 444-0457* *Kathleen.Annette@mail.ihs.gov*
Bemidji Area Representative: ***Sandra Ninham, Council Member*** *Oneida Nation of Wisconsin* *P.O. Box 365* *Oneida, WI 54155* *(920) 869-4458* *Fax (920) 869-4040* *sninham@oneidanation.org*	*Portland Area Representative:* ***Marilyn Scott, Chairwoman*** *Upper Skagit Tribal Council* *25944 Community Plaza Way* *Sedro Wooley, WA 98284* *(360) 856-5501* *Fax (360) 856-3175* *usclinic@yahoo.com*	*Federal Representative:* ***Robert McSwain,*** ***Director, Office of Management Support*** *12300 Twinbrook Pkwy Suite 625* *Rockville, MD 20852* *(301) 443-6290* *Fax (301) 443-2510* *rmcswain@hqr.ihs.gov*
Billings Area Representative: ***Jami Hamel, Vice-Chairperson*** *Confederated Salish and Kootenai Tribe* *P.O. Box 27* *Pablo, MT 59855* *(406) 675-2700* *Fax (406) 675-2806* *csktcouncil@cskt.org*	*Tucson Area Representative:* ***Francisco Munoz Jr., Tribal Council Member*** *Pascua Yaqui* *7474 South Camino De Oeste* *Tucson, AZ 85746* *(520) 883-5010* *Fax (520) 883-5014* *Francescomunoze@hotmail.com*	*Federal Representative:* ***Christopher Mandregan, Area Director*** *Alaska Area IHS* *4141 Ambassador Drive* *Anchorage, AK 99508* *(907) 729-3687* *Fax (907) 729-3689* *cmandreg@akanmc.alaska.ihs.gov*
California Area Representative: ***Rosemary Nelson*** *Modoc Rancheria* *Modoc Indian Health Project* *321 South Main Street* *Alturas, CA 96101* *(530) 233-2727* *Fax (530) 233-2606* *rlenlson@hdo.net*	*Tribal Self-Governance Advisory Committee Representative:* ***H. Sally Smith*** *Bristol Bay Area Health Corporation* *420 Mail Street* *Dillingham, AK 99576* *(907) 892-2434* *Fax (907) 842-4137*	*Federal Representative:* ***Dr. Doug Peter, CMO*** *Navajo Area IHS* *P.O. Box 9020* *Window Rock, AZ 86515-9020* *(928) 871-1479* *Fax (928) 871-5872* *Douglas.Peter@navajo.ihs.gov*
Nashville Area Representative: ***Buford Rolin, Council Member*** *Poarch Band of Creek Indians* *5811 Jack Springs Road* *Atmore, AL 36502* *(251) 368-9136* *Fax (251) 368-3757*	*National Congress of American Indians Representative:* ***Tex Hall, President*** *Chairman, Three Affiliated Tribes Ft. Berthold* *404 Frontage Road* *Bismarck, ND 58763* *(701) 627-4781* *Fax (701) 627-4748* *texghall@mhanation.com*	

GLOSSARY OF ACRONYMS

CDC	Centers for Disease Control and Prevention
DOD	Department of Defense
FEHP	Federal Employee Health Plan
FTE(s)	Full-time equivalents
FY	Fiscal Year
GPRA	Government Performance Results Act
HHS	Department of Health and Human Services
HR	Human Resources
IHS	Indian Health Service
IHCIA	Indian Health Care Improvement Act
IHDT	Indian Health Design Team
IT	Information Technology
I/T/U	"I" stands for programs delivered by IHS, "T" stands for programs delivered by Tribes through compacts or contracts, and "U" stands for Urban Indian Health programs.
OMB	Office of Management Budget
RIW	Restructuring Initiative Workgroup
VA	Department of Veterans Affairs

TRANSITIONS 2002: A 5-YEAR INITIATIVE FOR RESTRUCTURING INDIAN HEALTH

A Preliminary Report by the Restructuring Initiative Workgroup

Executive Summary

"Transitions 2002: A 5-Year Initiative For Restructuring Indian Health" contains 58 recommendations that will best enable accessible and acceptable health care services for American Indians and Alaska Natives during the next five years. This preliminary report was developed by the Restructuring Initiative Workgroup (RIW), a constituent-dominated group of 20 Indian health leaders -- Tribal Leaders, representatives of Tribal and urban Indian health programs and national Indian organizations, and Federal employees. The Workgroup provided this preliminary report to the Indian Health Service (IHS) to seek input from American Indian and Alaska Native people throughout Indian Country on the proposed recommendations and to incorporate their feedback into the final recommendations. This report will remain preliminary until consultation with Indian people is complete in August 2002.

The draft recommendations contained in the preliminary report are the result of the second formal restructuring process initiated by the IHS since 1995. The first process in 1995-97 was guided by the Indian Health Design Team (IHDT) and resulted in 50 recommendations that shaped today's IHS. The 1995-97 design effort focused on fixing the organization internally and resulted in streamlining the IHS Headquarters' organizational structure and decreasing administrative positions from the IHS Headquarters and Area Offices. The savings from the downsizing were reinvested in

front-line health delivery positions at local IHS hospitals and clinics and increased funding for Tribes and Tribal health organizations to provide health care under self-determination contracts and self-governance compacts. The IHS downsized to a greater degree than other agencies within the Department of Health and Human Services (HHS). Because the IHS had downsized previously and most recommendations were implemented after 1997, the RIW recommends that the IHS be exempt from the current HHS and Office of Management and Budget (OMB) proposals for work force reductions. In response to work force consolidation proposals, the RIW recommends the HHS first consult with American Indians and Alaska Natives in accordance with the HHS Tribal consultation policy. The RIW proposes alternatives to some of the HHS consolidation proposals and suggests alternatives that would decrease the disruption in services that could be caused by some of the HHS proposed consolidations.

The IHS is a Federal agency within the HHS. The IHS, in partnership with Tribes and urban Indian health organizations, provides personal and public health care services to American Indians and Alaska Natives. An estimated 1.6 million American Indians and Alaska Natives live in the IHS service area in counties on or near reservations. An estimated 332,000 American Indians and Alaska Natives are eligible to use the Urban Indian Health programs. The American Indian and Alaska Native people differ dramatically from other Americans in two health-related areas. First, they experience a substantially lower health status and greater mortality and morbidity as compared with U.S. All Races. Second, they have less per capita health care expenditures for personal health services as compared with U.S. All Races. Per capita health care expenditures for American Indians and Alaska Natives are lower than per capita expenditures for prison inmates. The RIW has concluded that increased resources and access to health care services will eliminate the disparities in funding and health. Therefore, the RIW recommends that the IHS budget be increased to $5 billion by 2007.

The recommendations proposed in this preliminary report transition the IHS to 1) focus on influencing the internal and external environment in which the Indian health system is doing business, 2) realign the system to carry out its work in a changing environment, and 3) guarantee culturally appropriate health care. Section one, "Facts and Figures about Indian Health," of this preliminary report provides a description of the American Indian and Alaska Native people, their substantially lower health status and higher morbidity and mortality rates as compared with U.S. All Races, and their limited access to health care. Section two, "Core Principles in Indian Health," identifies eight principles to American Indians and Alaska Natives that are important in the context of planning, delivering, and restructuring their personal and public health care services. Section three, "Getting the Job Done Effectively and Efficiently," underscores what the Indian health care system has already done to be an effective, efficient government program without diminishing the progress made in Indian health. In section four, "Short-Term Reforms," the RIW responds to government-wide and HHS initiatives and provides alternatives to promote the goal of eliminating health disparities between minority groups, including American Indians and Alaska Natives, and the general population. Section five, "Vision for the Future of Indian Health," describes a future for Indian people that will only be attained by eliminating health disparities and gaps in funding and services. Section six, "A Structure to Support the Vision for Health," presents recommendations for structuring the Indian health care system so that it can support the attainment of a healthy future for American Indians and Alaska Natives.

The RIW concluded that the IHS has successfully restructured

- the upper management level by streamlining the IHS Headquarters organizational structure from 140 to 40 organizational units and decreasing administrative positions by 60 percent, and
- the middle management level in the twelve IHS Area Offices by reducing administrative positions by 58 percent.

The resources gained through these reductions were reinvested into front-line health delivery positions which increased by 12 percent. The restructuring was made in accordance with the IHS Tribal consultation policy. The RIW considers this restructuring to be in alignment with the President's Management Agenda for Fiscal Year 2002. The RIW notes that the Administration has indicated that Federal agencies that have successfully restructured will be rewarded.

The RIW proposes the following recommendations to help meet the needs for American Indian and Alaska Native health.

2.1 The Administration, Congress, and Federal agencies must recognize the sovereign status of Indian Tribes.

2.2 The HHS must expand its services into American Indian and Alaska Native communities as a part of carrying out the Federal trust responsibility for health care services to Indian people.

2.3 The position of IHS Director must be elevated to the Assistant Secretary level within HHS to strengthen the government-to-government relationship between the United States and Tribes.

2.4 The President must appoint a liaison in the White House for Tribal Leaders and Indian organizations to 1) inform the Administration on the status of Tribes, 2) assist the Administration in addressing the consultation directives and policies related to American Indian and Alaska Native people and their communities, and 3) explore ways to address Indian issues.

2.5 The Federal Government must relate to Tribal Governments as a 51st State with respect to eligibility for direct access to funds from other HHS agencies and in the granting process of other HHS agencies.

2.6 The HHS Secretary must issue a directive that savings derived from IHS restructuring be exclusively reinvested in IHS mission-related activities.

2.7 The HHS Secretary must issue a letter about the One HHS initiative to Tribal Leaders to initiate Tribal consultation.

2.8 The HHS Secretary must activate the Intradepartmental Council on Native American Affairs.

2.9 The HHS Secretary must regularly meet with Tribal Leaders to address how HHS can better address Indian health issues.

2.10 The HHS Secretary must exempt the IHS from full-time equivalent (FTE) and budget reductions since the Agency is underfunded and had recently restructured in order to shift administrative resources to direct services in communities where Indian people are served.

2.11 Tribes must be consulted about the IHS/HHS/OMB budget early in the formulation process.

2.12 The IHS and HHS must consider the recommendations of the IHS/Tribal Public Health Support Workgroup and the Strategic Plan Workgroup.

2.13 The IHS and HHS must advocate for the Indian Health Care Improvement Act to become permanent legislation.

2.14 The IHS must clarify its Patient Bill of Rights to ensure both a high quality and level of services for American Indian and Alaska Native patients.

The RIW proposes the following recommendation for updating the IHS mission, goals, and foundation statements to ensure the Indian health system continues to meet the needs of American Indian and Alaska Native people.

3.1 The IHS use the proposed foundation, mission, and goal statements as working drafts on the issue date of this preliminary report and, if Tribal review and comments are favorable, the proposed statements replace the existing statements.

The RIW proposes the following recommendations to meet government-wide reforms.

4.1 The HHS maintain Legislative and Public Affairs in IHS to ensure that HHS gets timely information from and well-informed analysis about Indian Country.

4.2 The IHS Legislation and Public Affairs staffs must coordinate closely with other HHS agencies in national emergencies and on cross-cutting issues to ensure one voice for HHS.

4.3 The HHS should use performance contracts and inter-agency agreements to ensure accountability to the Secretary.

4.4 The IHS should consider realigning Human Resource (HR) support functions within IHS to take advantage of new technologies and enhance HR expertise available to all IHS health care delivery sites in 35 States.

4.5 To preserve the specialized experience and support for the dispersed community-based health care system, the IHS HR functions should not be consolidated with HR functions of highly dissimilar agencies.

4.6 The RIW maintains that many improvements envisioned by the Secretary can be achieved with internal restructuring focused on supporting needs in the front-line health delivery sites.

4.7 The IHS health care facilities and sanitation construction programs must remain within the IHS. Health facilities require a mission-critical focus to the specific program objectives of the IHS.

4.8 The RIW supports better management of federal office space that does not impact front-line Indian health care facilities.

4.9 The HHS and the IHS should identify in a memorandum of agreement additional steps to ensure full reporting and compliance of IHS facilities data with HHS standards.

4.10 The HHS should acknowledge the relatively higher health facilities needs of Indian Country compared to those of other HHS agencies.

The RIW recommends the following actions to achieve the proposed vision for attaining and maintaining Indian health and well-being.

5.1 The IHS funding must be doubled on a per capita basis to bring resources for Indian health in line with those available to other Americans.

5.2 Tribes and urban Indian health organizations must be ensured grant eligibility to access and share in health care resources of other HHS agencies.

5.3 The number of health care providers in the Indian health care system must be doubled.

5.4 Shortages of doctors, dentists, pharmacists, nurses and other health care providers in Indian Country must be eliminated through better recruitment, training, and compensation.

5.5 Aged, inadequate hospitals and ambulatory clinics must be replaced and modernized, and space and equipment sufficiently expanded for a growing Indian population.

5.6 Investments must be made in community infrastructure, especially for safe water supply and waste disposal — forms of municipal infrastructure that are virtually non-existent in remote areas of Indian Country.

To support the vision for a healthy Indian future, the RIW recommends:

6.1 The IHS organizational structures must allow flexible approaches to serve diverse Indian communities, traditions, principles and cultures.

6.2 Continue to decentralize, where possible, IHS management and decision making and control to the local level where health care is delivered.

6.3 Health service delivery decisions must occur at the local level and involve Tribal and community participation.

6.4 Shift the roles of IHS Headquarters and Area Offices from directing, controlling, and overseeing front-line programs to supporting them with needed administrative support and technical assistance.

6.5 Triple investment in information and communications technology over the next five years.

6.6 Create an interconnected Indian Health Network for approximately 300 widely dispersed health care sites to more effectively collaborate and pool information, expertise, and resources.

6.7 Standardize data systems and protocols be standardized to assure all locations work together using common standards for communication and interoperability.

6.8 Specify hardware and software standards to assure all sites maintain compatibility while preserving flexibility to select differing hardware.

6.9 Utilize compatible information systems developed in the much larger, better funded federal health care systems such as Department of Defense and Department of Veterans Affairs.

6.10 Develop a national data warehouse where consolidated data is retrievable from all sites throughout the Indian Health Network.

6.11 Expand efforts and remove barriers for the IHS to work with other HHS agencies.

6.12 Tribal eligibility for grants must be obtained across the HHS and other Federal Departments, especially for newly created programs for homeland security and bioterrorism.

6.13 Remove barriers (Title XIX) that prevent Tribes from contracting directly (51st State concept).

6.14 Assess additional roles for the IHS in the area of environmental health, e.g., hazardous and nuclear waste and water quality.

6.15 Address provision of technical support and funding for newly recognized Tribes.

6.16 Improve the IHS/HHS/OMB budget process to allow for better access and follow-up by Tribes.

6.17 Expand third-party billing capabilities at all sites in the Indian health care system.

6.18 All organizational reforms within IHS must support and accommodate Tribal rights to compact, contract, or retain IHS to operate health programs directly.

6.19 The IHS must track resources that are realigned to ensure that Tribal shares for which each Tribe is eligible are not reduced as consequence of reforms and restructuring, any shares re-allocated not lose identity as Tribal shares, and any savings resulting from restructuring be applied to programs delivered directly by the IHS, by Tribes through compacts or contracts, and by the urban Indian health programs (I/T/Us).

6.20 Conduct assessments of the Office of Tribal Programs, IHS direct programs, and the IHS Urban Indian Health Program to complement the assessment by the Office of Tribal Self-Governance.

6.21 The extent and type of restructuring of these offices must be in accordance with the extent of compacting, contracting, direct, and urban Indian health programs.

6.22 Develop contingency plans to minimize disruptions in delivery of health care services in the event a Tribal contract or compact is retroceded.

6.23 The IHS must carefully manage large transfers of Tribal shares to ensure a smooth and orderly transition of programs, activities, functions, and services to Tribes. The magnitude of the transfers is one of the reasons that further Federal FTE cuts for IHS should be reviewed with caution.

6.24 The impediment for additional Tribal contracting and compacting can be removed by fully funding contract support costs and other one-time costs of transition.

6.25 The IHS should support efforts by Tribes to form Tribally chartered organizations to offer business and administrative support services.

6.26 Tribes must be consulted about the benefits and costs of a range of approaches to reform engineering services.

6.27 The RIW recommends holding at least one additional meeting to consider and incorporate feedback from Indian Country and to refine long-range plans for reforming the Indian health care system.

Your feedback about these recommendations is welcome. Please send your comments to:

Indian Health Service
801 Thompson Avenue, Suite 220
Rockville, MD 20852

Or

RIW@MAIL.IHS.GOV

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FACTS & FIGURES ABOUT INDIAN HEALTH

A Proactive, Citizen-Centered Approach To Restructuring

Since 1995, the Indian Health Service (IHS), guided by the American Indian and Alaska Native people it serves, has been adapting to a changing environment by maintaining its strengths and responding, as necessary, to opportunities and challenges. In February 2002, the IHS charged a representative group of 20 Indian health leaders to identify changes to the Indian health care system that will best enable accessible and acceptable health care services for American Indians and Alaska Natives during the next five years.

The Restructuring Initiative Workgroup (RIW) is a group of Indian health leaders representing key stakeholders in Indian health -- Tribal Leaders, representatives of Tribal and urban Indian health programs and national Indian organizations, and Federal employees. When the RIW met to discuss the Indian health care system, the group focused on the people they represent 1.6 million American Indians and Alaska Natives who are members of 560 federally recognized Tribes eligible to receive health care services from IHS or IHS-funded programs.[1] The RIW discussed how to make a positive difference in the health and well-being of the people living in Indian Country. Indian Country means 661 counties on or near reservations and in rural communities in 35 States where many Indian

people live. An estimated 332,000 American Indians and Alaska Natives are eligible to use the Title V Urban Indian Health programs at 36 urban sites.

The first stakeholder-driven design initiative for the Agency in almost 40 years spanned 18 months from 1995 to 1997 and recommended organizational and structural changes that shaped the current organization. When the recommendations were implemented, a new IHS emerged. The new IHS changed its organizational climate, shifted resources and decision making to the local level where services are delivered, and incorporated new and improved ways of doing business for IHS and IHS-funded programs. By including the people it served in the design initiative and implementing the changes they recommended, the IHS reduced the stigma of federal paternalism that has characterized other federal agencies in serving Indian people.

In 2002, the environment has changed enough for the IHS to again plan for its future. This preliminary report, "Transitions 2002: A 5-Year Initiative for Restructuring Indian Health," describes how key stakeholders in Indian health are continuing the Agency's design and transition process. The process includes Tribal consultation before IHS takes any actions that affect American Indian and Alaska Native people. The IHS will make this preliminary report available to Indian Country and provide a mechanism for feedback on the proposed recommendations.

Whereas the 1995-97 design effort focused on fixing the organization internally, this year's effort focuses on influencing the internal and external environment in which the Indian health system is doing business and realigning the system to carry out its work. The RIW proposes that resources and access to health services be increased to eliminate the disparities in funding and disease between American Indians and Alaska Natives and other Americans. The RIW proposes

recommendations to restructure the Agency so that continued access to culturally appropriate health care is guaranteed.

This preliminary report presents updated statements for the IHS mission, goals, and foundation. It also presents short-term and long-term recommendations for responding to change, opportunities, and challenges during the next five years for improving services to American Indians and Alaska Natives. This preliminary report submits the Workgroup's proposed recommendations to the IHS for review and consultation by Indian Country to ensure the people served by the IHS are involved in guiding decisions that affect their health care services. This report will remain preliminary until consultation with Indian Country is completed in August 2002.

By this preliminary report, the Workgroup encourages dialogue within Indian Country to address the question: In a changing environment, how will the operators of Indian health care programs continue to provide quality health care to American Indians and Alaska Natives? The answer to this question will emerge after consultation is completed and the Indian people have provided their response to the IHS.

Poverty and Despair in Indian Country

American Indians and Alaska Natives have not fully shared in America's growing prosperity. The people in Indian Country are experiencing health problems and living conditions that shorten their lives by 5.9 years compared to other Americans.[2] An American Indian or Alaska Native born today has a life expectancy of 70.6 years compared to other Americans who on average will live to be 76.5.[3] The 1996-98 infant mortality rate for American Indians and Alaska Natives residing in the IHS service area was 8.8 (rate per 1,000 live births) in

1997-99 compared to 7.2 for the U.S. All Races population in 1998. The Indian rate is 21 percent higher that the U.S. rate.[4] The people in Indian Country are dying at rates higher than other Americans.

Alcoholism	**670%**
Tuberculosis	**650%**
Diabetes	**318%**
Unintentional injuries and accidents	**204%**
Suicide	**92%**
Homicide	**105%**

Figure 1.1: Higher Indian Deaths than U.S. All Races. [5]

Safe water and adequate waste disposal facilities are lacking in 7.5 percent of Indian homes compared with 1 percent of homes in the U.S. general population. In some parts of Indian Country, 35 percent of homes lack these systems. These facts represent the poor environmental conditions in which many Indian people live. A safe and adequate water supply and waste disposal system contributes to the health of communities. Approximately 30,180 Indian homes still lack either or both a safe water supply and adequate waste disposal system. The IHS has identified a total backlog of 2,902 needed sanitation facilities construction projects costing $1.6 billion to provide all American Indians and Alaska Natives with safe drinking water and adequate waste disposal facilities in their homes.[6]

American Indians and Alaska Natives are younger with less formal education and less income than the U.S. population in general. The IHS service population increases at a rate of approximately 2.5 percent per year.[7] This increase further taxes the Indian health care system to meet the health needs of Indian Country.

The American Indian and Alaska Native population have long experienced lower health status when compared with the U.S. general population. Their lower life expectancy and disproportionate disease burden exists in part because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity or poor social conditions. American Indians and Alaska Natives are still suffering poverty and despair amidst America's abundance.

Given the higher health status enjoyed by most other Americans, the health disparities of American Indians and Alaska Natives are troubling to Tribal Leaders, health care experts, and policymakers. When American Indians and Alaska Natives get sick, 62 percent rely on the IHS for access to health care. Their health care is provided in 49 hospitals and more than 550 ambulatory facilities operated directly by the IHS, Tribes and Alaska Native health corporations, and urban Indian health organizations. In fiscal year (FY) 2002, the Federal budget appropriation for the IHS is $2.8 billion. This will fund approximately 273,000 inpatient days, 7.8 million outpatient visits, and other personal and public health services.[8] Some of the health care is purchased by IHS or through IHS-funded programs from an estimated 2,000 private health care providers when services are not available in the local Indian hospital or clinic.

Once American Indian and Alaska Native people access the services of IHS or an IHS-funded program, their per capita personal health care expenditure is lower than that of other Americans ($1,776 compared to $4,392).[9] The American Indians and Alaska Native people receive lower health expenditure per capita than other Federal program beneficiaries receive.[10]

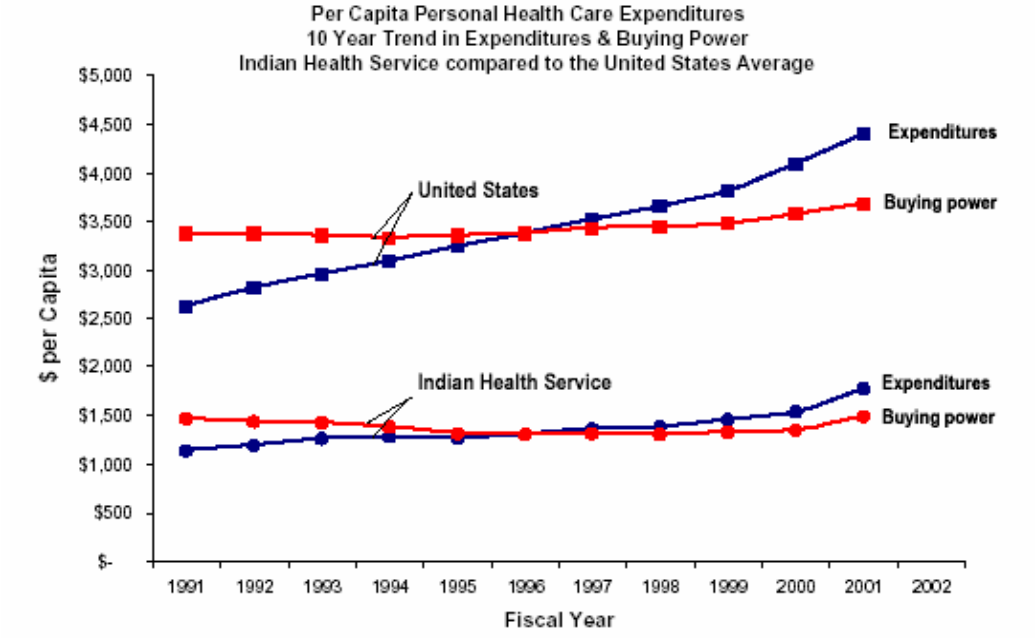

Chart 1.1 – Per Capita Personal Health Care Expenditures

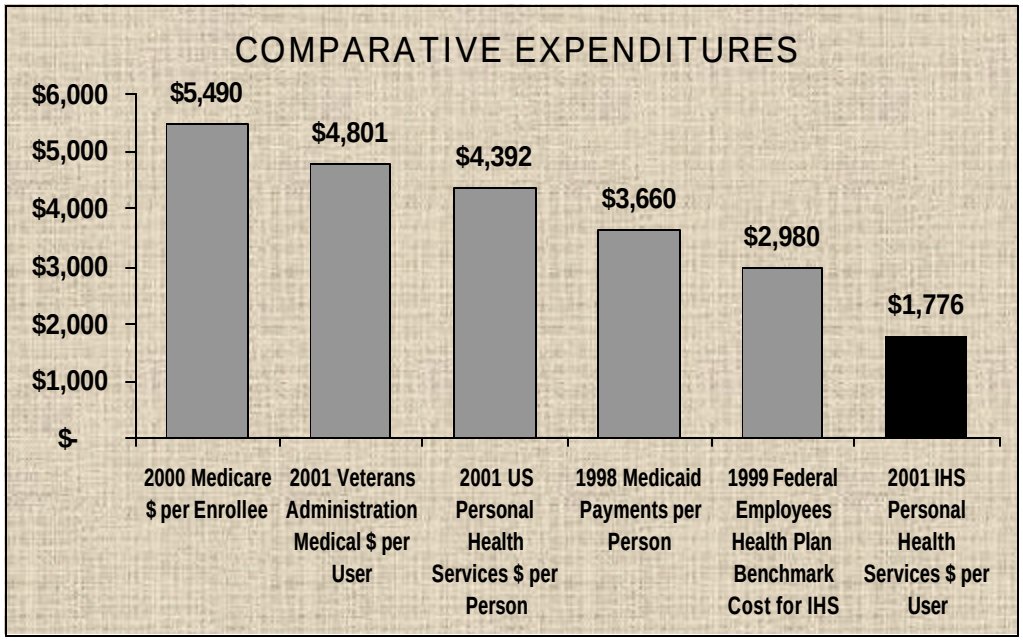

Chart 2.1 – Comparative Expenditures [11]

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CORE PRINCIPLES IN INDIAN HEALTH

The best approach to Indian people requires considering the principles that are important to them. These principles are the lens through which the people of Indian Country see change. In the past, policy makers and decision makers have either ignored or resisted the importance of Indian health principles as they have tried to make Indian people adapt to change. The RIW identified eight core principles in Indian health that are fundamental to meaningful dialogue with American Indians and Alaska Natives. They are:

- A Health Care System for Indian People
- Tribal Sovereignty
- Federal Trust Responsibility
- Government-to-Government Relationship
- Tribal Consultation
- Self-Determination
- Pre-Paid Health Care
- A Special Appropriation for a Special Mission

A Health Care System for Indian People

The IHS obtained its unique status under three acts of Congress. The Snyder Act of 1921 is the first and principle legislation authorizing federal funds for health services to federally recognized Indian Tribes. The Act authorizes funds

"... for the relief of distress and conservation of health ... [and] for the employment of ...physicians...for Indian tribes throughout the United States." Next, the Indian Self-Determination and Education Assistance Act of 1975, as amended, gave Tribes the option of either to assume the administration and operation of health services and programs in their communities from the IHS or to remain within the IHS-administered direct health care system. Third, the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, is a health-specific law. It has established the IHS as part of the Public Health Service, as the principal Federal advocate for the health of all Indian people and as the Agency responsible for elevating the health status of Indian people to the highest level possible. This Act was the first of the three laws to address the important needs of American Indians and Alaska Natives who live in urban areas in addition to those needs of Tribal members who remain on or near their reservations.

All IHS issues have particular requirements of Indian statutory and Constitutional law and must be considered within the special government-to-government relationship between Tribal nations and the Federal Government. Answers and/or advice generally applicable to other Department of Health and Human Services (HHS) agencies cannot be presumed to be applicable to the IHS. As an operator of direct health care services, the IHS must take into account the full scope of legal issues affecting health care providers. In addition to operating the IHS direct health service program, the Agency is also responsible for helping Tribal Governments operate and manage their own health programs. This includes transferring Agency resources to Tribal Governments to support these operations. The IHS must comply with the Federal law on Indian Preference. The purpose of this hiring preference is to support Indian participation in self-government.

In 1955, the IHS was transferred to what was then known as the Department of Health, Education, and Welfare, now known as the Department of Health and

Human Services which is one of 14 departments of the executive branch of the Government. Among HHS agencies, IHS is one of the few agencies that deliver directly personal and public health services to its constituents. The Agency's respect for cultural beliefs, blending of traditional practices with a modern medical model, and emphases on public health and community outreach distinguish it. The Agency's respect for cultural beliefs and its blending of traditional and modern practices might serve as a model for indigenous people around the world. Its emphasis on community-based outreach activities might serve as a model for other HHS agencies with less developed outreach models. Its consultation practices could be a model for the entire Federal Government in an era of strengthening community-based services and citizen-centered approaches to delivering services.

Tribal Sovereignty

Tribes are sovereign nations. They are political entities — not a racial classification of people or a special-interest group. Tribal nations, with their own governing structures and political systems, existed long before the Europeans landed on Indian Country shores and the United States was formed. The distinction of Tribes as self-governing entities is mentioned in the Constitution of the United States. After the United States was formed and early in U.S. history (the 18th and 19th centuries), the U.S. Government recognized Tribal sovereignty and entered into more than 800 treaties with Tribes. The purpose of these treaties was mainly to exchange Tribal homeland for protection and federal services. Therefore, the provision of federal services to Indian people has most of its origin in treaties. In addition to treaties between individual Tribes and the United States, federal services were also provided through acts of Congress, statutes, Presidential Directives and Executive Orders, and court decisions.

Tribal Leaders have always maintained that Tribal sovereignty is paramount among Indian principles.

Federal recognition acknowledges the Tribe as a government and establishes government-to-government status between the Tribe and the Federal Government. This status also provides members of the Tribe with certain federal services. One of these services is health care.

Federal Trust Responsibility

The protection of the inalienable right to Tribal self-government is a responsibility of the Federal Government. The legal instruments cited in the preceding section create a Federal Trust Responsibility to American Indians and Alaska Natives and their Tribal Governments. The Federal Government must uphold its trust responsibility.

Indian people are vitally connected to their identity as members of sovereign nations. Federal policymakers must not forget how American Indians and Alaska Natives gave up their homelands for social, medical, and educational services to help form a more perfect union.

Government-to-Government Relationship

The U.S. Constitution recognizes the political status of Tribal Governments and equates their status with the accord provided to foreign nations: "The Congress shall have power ... to regulate commerce with foreign nations ... and with Indian tribes." Tribes exercise powers of government. They form their own governing systems, determine who belongs to the Tribe, and elect their own leaders. Tribal Leaders, representatives of their nations, expect full, open communication with

Federal leaders and expect to be consulted about changes that affect them. When Federal leaders avoid full and open communication with Tribal Leaders or exclude them from dialogue about policy, programs, and services, Indian people interpret that behavior as diminishing the government-to-government relationship. Sensitivity about this relationship is very high among Indian principles because the Federal Government has broken so many promises to American Indian and Alaska Native people.

Tribal Consultation

The special government-to-government relationship ensures that Tribal nations have maximum participation in the direction of federal services to Indian communities. Participation is ensured through Executive Orders, Departmental policy, and Agency policies that establish Federal consultation with Tribal nations. This participation is necessary so that Tribal Leaders can express the needs of Indian communities to Federal leaders and federal service can be responsive to these needs.

Consultation with Tribal nations is to occur when actions are proposed and before actions are taken that affect Indian communities. The HHS policy on Tribal consultation states:

> "Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision making."

The meaning of consultation is to communicate, discuss, and confer in order to make a decision or reach a settlement. This concept is not new to the U.S. Government. The signers of the Constitution referred to the concept of "consent of the governed" which is a cornerstone of a government for and by the people.

Self-Determination

In exercising self-determination, Tribal Governments are empowered to choose the management direction of their health care. They can receive their health care directly from the IHS; contract with the IHS to provide services; or compact with the IHS and have the administrative control, operation, and funding transferred to Tribal Governments. More than half of IHS resources have been contracted or compacted to Tribal Governments. Tribal empowerment through self-determination and self-governance management and delivery of health care will increase in the future. The IHS must continually transition as Tribes exercise self-determination. Since Indian self-determination was enacted, Congress has strengthened the self-determination policy. The Act was originally articulated by President Nixon and signed into law by President Ford.

Pre-Paid Health Care

American Indians and Alaska Native Tribes have pre-paid for health care benefits for their people through the loss of millions of acres of land and other resources. Some of the original treaties specifically state that health care will be provided as a part of the U.S. Government's responsibility. The issue of whether health care services for Tribes is or should be viewed as an entitlement is currently being discussed and considered by a number of national workgroups and committees. It is the position of a number of Tribal Governments that health care was an integral part of their respective treaties between the Tribe and the U.S.

Government. The pending reauthorization of the IHCIA would help clarify the role of the Federal Government as it pertains to Indian health care issues. The RIW members believe that the IHCIA should be permanent.

Recent studies have validated the significant health disparities that American Indians and Alaska Natives experience compared with U.S. All Races. The Federal Employees Health Plan (FEHP) Disparity Index Study shows that many Tribes are funded below the 50 percent level of need funding. Given the magnitude of the health disparities and the limited funding, the RIW members believe that this is an excellent opportunity for the IHS to clarify its Patient's Bill of Rights. This would help to clarify the quality and level of services patients should expect.

A Special Appropriation for a Special Mission

The IHS budget is not a direct appropriation to the HHS but comes to the IHS through the Interior and Related Agencies appropriations. The appropriations are specifically for the provision of health care services to American Indian and Alaska Native people.

Federal health care services to Indian people are not funded as an entitlement. Increasing costs from rising inflation and an expanding beneficiary population are not covered automatically. Because the IHS budget competes for limited discretionary appropriations with other federal programs, IHS appropriations have never been sufficient for health care needs in Indian Country. There has been little progress in closing the gap because IHS buying power has not kept pace with the growing beneficiary population of Indian Country. Consequently, this underfunded health care system has been unable to eliminate the health disparities experienced by Indian people.

The RIW proposes the following recommendations to help meet the needs for American Indian and Alaska Native health.

2.1 The Administration, Congress, and Federal agencies must recognize the sovereign status of Indian Tribes.

2.2 The HHS must expand its services into American Indian and Alaska Native communities as a part of carrying out the Federal trust responsibility for health care services to Indian people.

2.3 The position of IHS Director must be elevated to the Assistant Secretary level within HHS to strengthen the government-to-government relationship between the United States and Tribes.

2.4 The President must appoint a liaison in the White House for Tribal Leaders and Indian organizations to 1) inform the Administration on the status of Tribes, 2) assist the Administration in addressing the consultation directives and policies related to American Indian and Alaska Native people and their communities, and 3) explore ways to address Indian issues.

2.5 The Federal Government must relate to Tribal Governments as a 51st State with respect to eligibility for direct access to funds from other HHS agencies and in the granting process of other HHS agencies.

2.6 The HHS Secretary must issue a directive that savings derived from IHS restructuring be exclusively reinvested in IHS mission-related activities.

2.7 The HHS Secretary must issue a letter about the One HHS initiative to Tribal Leaders to initiate Tribal consultation.

2.8 The HHS Secretary must activate the Intradepartmental Council on Native American Affairs.

2.9 The HHS Secretary must regularly meet with Tribal Leaders to address how HHS can better address Indian health issues.

2.10 The HHS Secretary must exempt the IHS from full-time equivalent (FTE) and budget reductions since the Agency is underfunded and had recently

restructured in order to shift administrative resources to direct services in communities where Indian people are served.

2.11 Tribes must be consulted about the IHS/HHS/OMB budget early in the formulation process.

2.12 The IHS and HHS must consider the recommendations of the IHS/Tribal Public Health Support Workgroup and the Strategic Plan Workgroup.

2.13 The IHS and HHS must advocate for the Indian Health Care Improvement Act to become permanent legislation.

2.14 The IHS must clarify its Patient Bill of Rights to ensure both a high quality and level of services for American Indian and Alaska Native patients.

3

GETTING THE JOB DONE EFFECTIVELY & EFFICIENTLY

In this section, the RIW presents some of the important changes that IHS has made in recent years to get the job done effectively and efficiently. The IHS has been restructuring since 1995 as a result of the first stakeholder-driven design initiative, which recommended organizational changes that shaped how IHS looks today.

With respect to the FTE and budget reductions proposed in IHS FY 2003 budget justification, the RIW view is that the IHS has been downsizing administrative FTEs and redirecting FTEs to program functions for years. The reference time frame for this Administration begins in 2002. However, the reference time frame for the Indian health system begins much earlier.

Equally important in shaping IHS are the changes stimulated by transferring resources for programs, functions, services, and activities to Tribes to support their rights for self-determination and self-governance. By FY 2002, more than half of the IHS budget had been transferred to Tribes. No other HHS agency has had to deal with a cash outflow of this magnitude. Since the budget has not adequately covered the outflow, the IHS has had to tighten its belt continuously over the past decade. During the last ten years no other HHS agency has

experienced the same level of downsizing pressures as those experienced by the IHS.

In looking at the long-term trends, the RIW observed the IHS began serious reorganization in the mid-1990s that has reduced the IHS Headquarters and Area Offices administrative ranks by more than half. The charts below show that IHS has made prudent use of its resources and has redirected savings from administrative downsizing to program services.

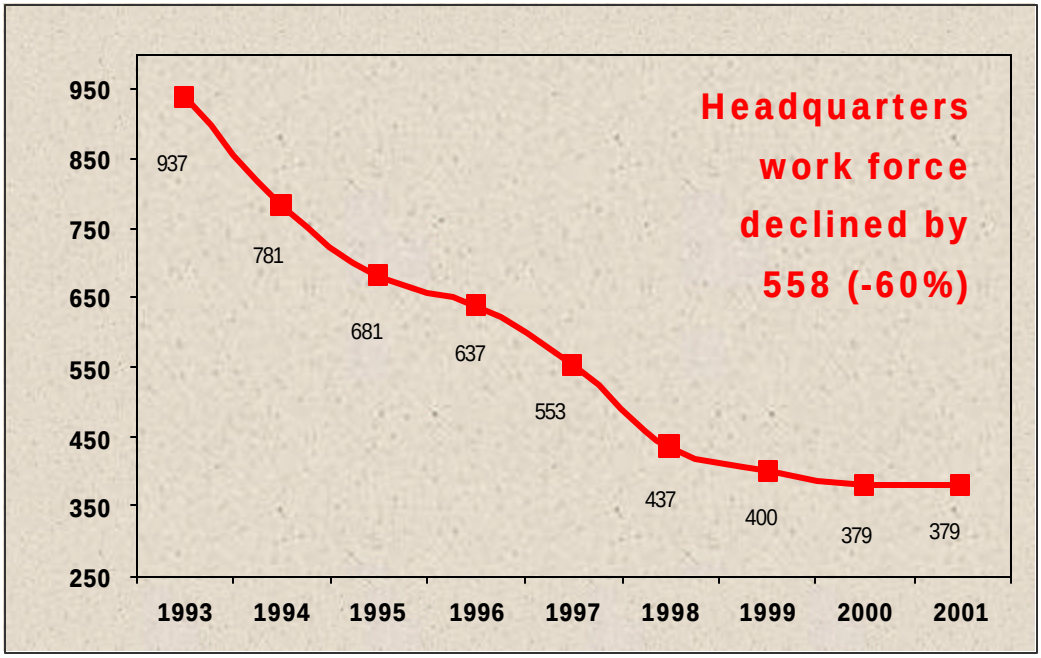

Chart 3.1 - Headquarters administrative ranks have been reduced

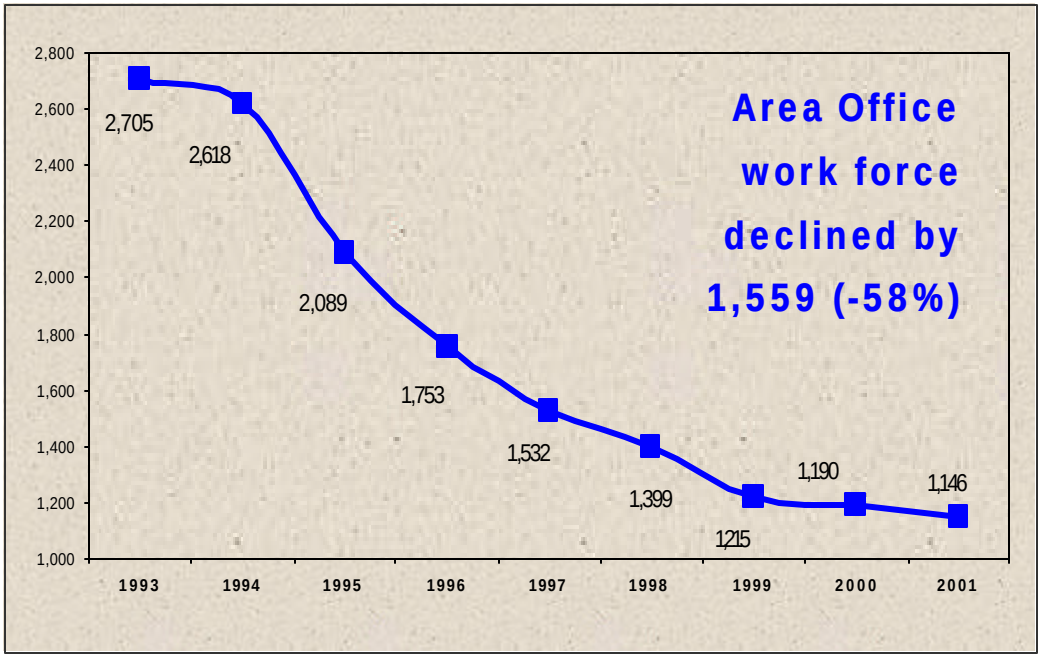

Chart 3.2 - Area Offices administrative ranks were reduced.

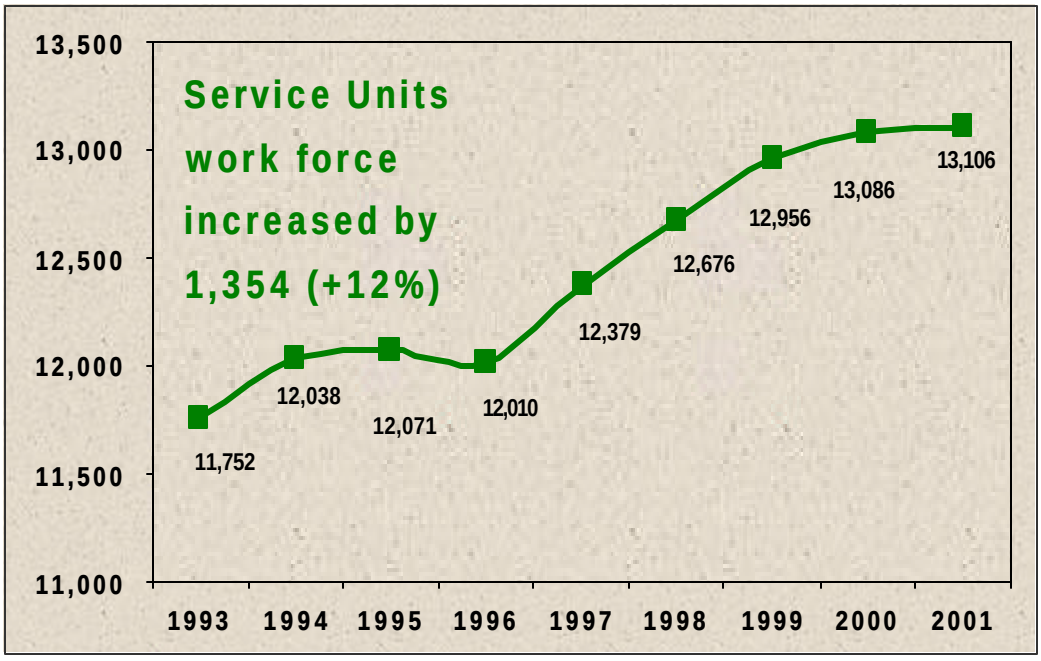

Chart 3.3 - Front-line health care work force has grown.

The FTE reduction in IHS management layers has been significant and has implications for the extent of additional restructuring that is prudent and practical. The IHS has achieved downsizing during the past 6-8 years and its administrative functions are now about as lean as can reasonably be expected.

As part of the 1995-97 redesign of IHS, Indian leaders specified that IHS' organizational structure should be streamlined and duplicate and unnecessary offices be consolidated or eliminated. Before the redesign, the IHS Headquarters had over 140 individual organizational elements in 8 operational divisions. Today, IHS Headquarters has 40 organizational units aligned into 3 operational divisions. The IHS Headquarters reduced by 100 organizational units and 5 operational divisions. See insert, Chart 3.4: IHS Headquarters Streamlined.

Downsizing and restructuring of IHS administration will continue as additional Tribes take over IHS functions in self-determination contracts, self-governance compacts and self-governance compacts. The IHS cannot absorb the FTE cuts specified in the FY 2003 IHS budget and simultaneously downsize FTEs required to transfer programs to Tribes over the next few years. The pace and magnitude of the combined reductions are of serious concern to the RIW because of the increased risk of disruptions of services.

Moreover, transfers of FTEs and resources from the IHS appropriation to other HHS appropriations are of great concern. Tribes have the right to contract and compact for IHS resources. Transferring resources and FTEs out of the IHS will diminish these rights. As a consequence, Tribes will have fewer resources available to operate the health programs. The RIW is opposed to FTE and resource transfers that detract from Tribal rights and potential operating resources.

IHS Headquarters Streamlined

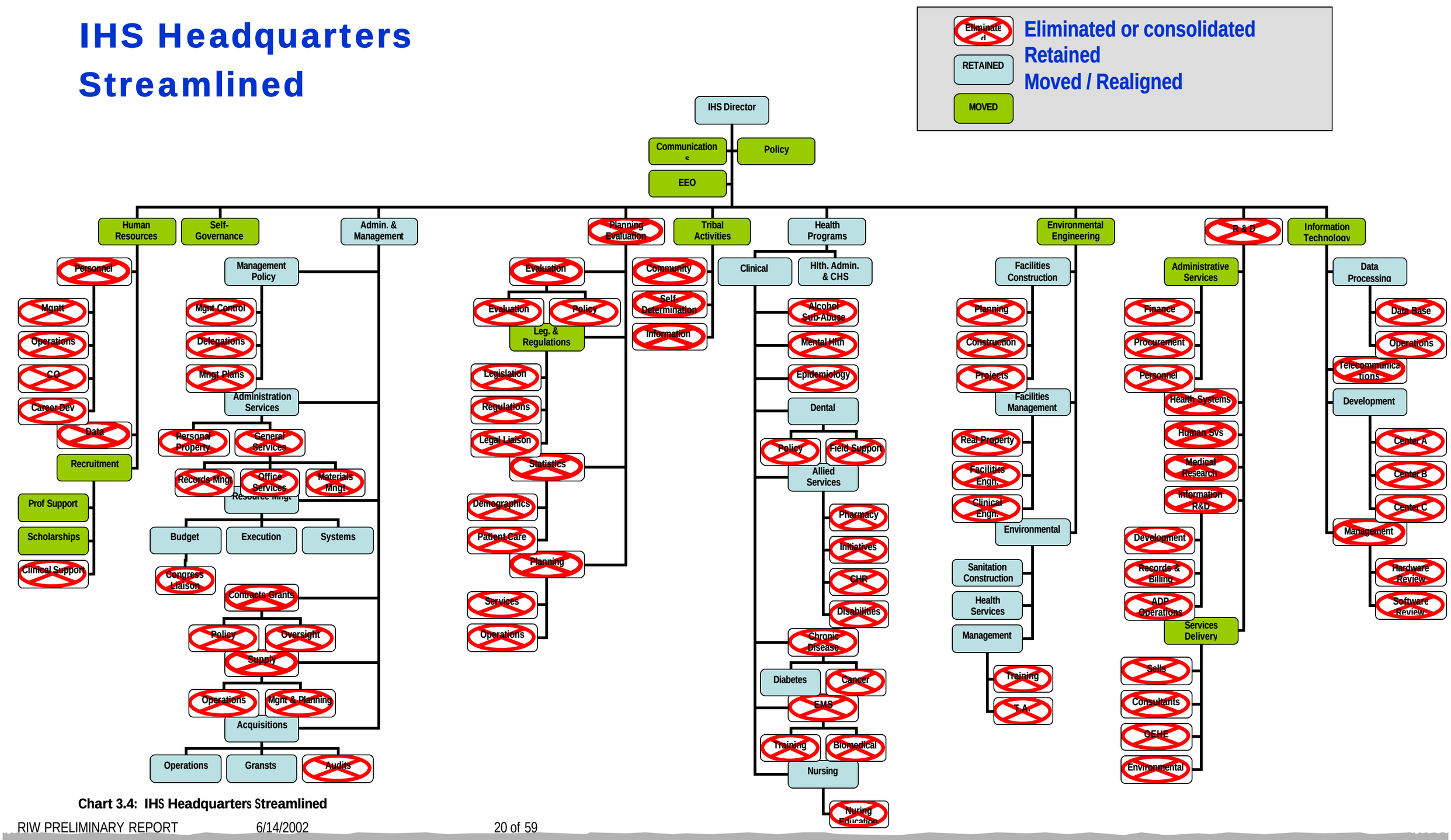

Chart 3.4: IHS Headquarters Streamlined

The FTE and resource transfers proposed by the HHS will actually diminish resources and services to Indian people. This is counter-productive to the Administration's goal to eliminate health disparities for American Indians and Alaska Natives. Health care resources and services must be increased to American Indians and Alaska Natives.

Progress In Indian Health

Despite the challenges and inadequate resources, Indian health has made progress in achieving its goal to improve the health of American Indians and Alaska Natives. The restructuring at IHS, shaped with participation of Indian people, have contributed to this success. Since 1973, Indian life expectancy has increased by 12.2 years. Mortality rates for American Indians and Alaska Natives have decreased significantly in many areas since 1973. Percentage-wise, the successes are reductions in death rates for:

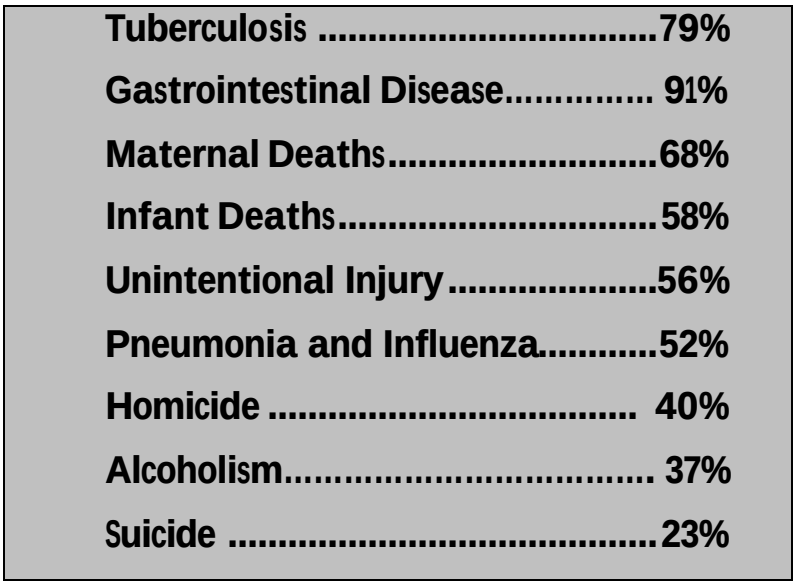

Figure 3.1: Reductions in American Indian Death Rates Since 1973

Building on Progress

Even with IHS reforms and the progress in improving health, much more must be done to achieve the goal to eliminate the disparities in health status and resources. In this preliminary report, the RIW members identify the steps leading to a long-range vision when Indian people do not experience health disparities and the Indian health care system has enough resources. The first step is to review the IHS mission for achieving that long-range vision.

Revised Mission, Goals, And Foundation

It is important to periodically review whether the organization's mission still defines its work and whether its goals still best describe the desired outcomes. The RIW members agreed that the IHS mission must include environmental health because to American Indians and Alaska Natives wellness is a state of harmony and balance among mind, body, spirit, and environment. If the environment is unhealthy, the state of wellness is compromised.

Proposed Mission

The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, environmental, and spiritual health to the highest level.

Figure 3.2: Proposed Mission

The IHS should retain the existing goal for providing health services to Indian people and add a goal for eliminating health disparities between American Indians and Alaska Natives and the general population.

Proposed Goals

The Indian Health Service shall provide high-quality, comprehensive, culturally appropriate personal and public health services to all American Indians and Alaska Natives. The Indian Health Service shall eliminate all health disparities that exist between American Indians and Alaska Natives and the general population.

Figure 3.3: Proposed Goals

After considering the existing foundation statement, the RIW revised the language to highlight Tribal sovereignty, Trust Responsibility of the Federal Government, and government-to-government relationship between Tribal and Federal Governments.

Proposed Foundation

The United States has a unique legal and political relationship with American Indian and Alaska Native Tribes as set forth in the U.S. Constitution, treaties, statutes, Presidential Directives and Executive Orders, and court decisions. These legal instruments create a Federal Trust Responsibility to American Indians and Alaska Natives. This trust responsibility includes, but is not limited to, the protection of the inalienable right to Tribal self-governance and the provision of social, medical, and educational services for American Indians and Alaska Natives. The Department of Health and Human Services shall honor and uphold its Federal Trust Responsibilities and the inherent sovereign rights of American Indians and Alaska Natives.

Figure 3.4: Proposed Foundation

The RIW believes that the proposed mission, goals, and foundation statements are the best overall definitive statements for guiding the IHS during the next five years. The RIW offers the proposed mission, goals, and foundation statements for review and comment.

The RIW proposes the following recommendation for updating the IHS mission, goals, and foundation statements to ensure the Indian health system continues to meet the needs of American Indian and Alaska Native people.

3.1 The IHS use the proposed foundation, mission, and goal statements as working drafts on the issue date of this preliminary report and, if Tribal review and comments are favorable, the proposed statements replace the existing statements.

4

GETTING THE JOB DONE EFFECTIVELY & EFFICIENTLY

Part of the RIW's charge is to identify how Indian health fits into the President's Management Agenda and the HHS restructuring initiative called One HHS. The President's Management Agenda is intended to result in a Government-wide reform to make the Government citizen-centered, results-oriented, and market-based. The RIW believes the IHS has already addressed many of the President's goals.

Part of the One HHS initiative is to consolidate some common functions now carried out in all HHS agencies and move them to the Departmental level. The purposes of One HHS are to achieve economies of scale and communicate with One HHS voice through consolidations, and to save money by reducing FTE in all HHS agencies. To save money, the HHS wants to reduce the number of government workers (full-time equivalents or FTE). For IHS, this means a reduction of 100 FTEs by the end of FY 2003. Some of the proposed consolidations to bring about One HHS have caused some concern among RIW members. In this report, the RIW shares the concerns of Indian Country and presents some alternatives to the One HHS proposals. The RIW members believe their recommendations respond to the President's Management Agenda overall.

The RIW strongly supports the HHS' national goal to eliminate health disparities between American Indian and Alaska Native people and other Americans. The Workgroup's long-range vision for Indian health fits perfectly with this national goal and with the goals of Congress as expressed in the IHCIA. However, the HHS initiatives can diminish the goal by decreasing IHS resources, which are already underfunded. The consolidations will make the gap worse. The RIW members believe that HHS must reconsider any restructuring actions that would result in counter-productive funding reductions for Indians and consider reinvesting some of the HHS restructuring savings to eliminate the funding disparities for Indian health.

The HHS is striving to improve efficiencies, streamline, and build cohesion among all HHS agencies. The RIW understands the realities of belt-tightening and why the Indian health system must continually transition to be more productive and effective. Because real buying power of the Indian health system has not kept pace with the growing beneficiary population, the IHS has been streamlining, reducing staff, and restructuring to make the belt fit for many years.

The RIW is considering organizational reforms at IHS that will continue to benefit front-line delivery of services to Indian people. However, the IHS cannot focus solely on belt-tightening because this approach cannot close the gap in services or eliminate health status disparities. In fact, if health disparities are to be eliminated, Indian health care services must be expanded. All restructuring savings derived from IHS consolidations must be reinvested into additional health care services to American Indian and Alaska Native people.

The HHS proposes to consolidate the functions listed below. Some of these functions will be consolidated immediately into the HHS by the end of FY 2003. Others will be consolidated in FY 2004 and FY 2005.

Figure 4.1: HHS Proposed Consolidations

The RIW has identified the following concerns about consolidating IHS functions within HHS.

- The HHS consolidations will detract from the Government's responsibility to preserve Tribal sovereignty and will diminish services to the already underserved Indian population.
- The savings generated from the increased efficiencies of One HHS will not be reinvested in Indian health care.
- Characteristics unique to the Indian health system (Indian Preference, different budget and oversight committees, Tribal shares, and how the system is based in hundreds of remote Indian communities – very different in structure, function and location from most HHS agencies) may not blend well with other HHS agencies lacking these characteristics.
- Resources consolidated from the IHS will be diluted, lose focus, and jeopardize the specialized experience and support services relied on by the front-line, community-based health care system.
- The HHS consolidation proposals have not been sufficiently detailed to adequately evaluate their merit or impact. Without the details and Tribal consultation, the RIW is unable to conclude the best course of action and are reluctant to endorse some proposals because of this uncertainty.

Alternatives

The RIW's main concern is that consolidation of IHS functions within HHS will reduce resources for Indian health and make the disparities and funding gap worse, not better. In light of this counter-productive result, the RIW suggests that HHS reconsider its consolidation proposals and explore alternative ways to achieve its goal to bring about One HHS.

Although the RIW cannot endorse all the HHS consolidation proposals, the RIW offers alternatives that will lessen the concerns and serve to creatively and constructively participate in the One HHS initiative while resisting a loss of resources to Indian health. The alternatives are generally consistent with the President's and the Secretary's goals but achieve them in ways that are less disruptive to the Indian health system.

Consolidation of IHS Public Affairs and Legislative Affairs

Consolidating IHS public affairs and legislative affairs staffs with other HHS staffs means that the HHS proposes to transfer 8 FTEs ($779,000) from the IHS to the HHS.

The RIW identified advantages to the transfers. The staffs will not physically relocate from the IHS Headquarters office. Because they are physically remaining at IHS offices, they will maintain their immediate access to IHS leadership. The transfers to HHS could make the IHS better connected to the HHS and raise the visibility of IHS issues and Indian Country's concerns.

The RIW also identified disadvantages to the transfers. The positions could lose their Indian Preference status. The Tribal shares connected to the resources

that support the positions could be lost if they are not tracked. The IHS focus in staff assignments and work products could be diluted if the staffs become absorbed in HHS work assignments and products. Responses to Indian Country could be delayed because of the longer time it may take to clear work products.

In general, Tribal Leaders strongly oppose the transfer of the legislative affairs function. The IHS Legislative Affairs staff serves as a critical liaison to Congress, Tribal Governments, and Indian communities as well as between the IHS and the HHS administrations. To be effective, the staff must be closely connected with IHS administrative offices. Consolidating IHS Legislative Affairs has been discussed in many forums throughout Indian Country, and the response from Tribal Leaders is that this function should not be transferred from IHS. The HHS already closely supervises the IHS legislative staff for on the record activities. Why consolidate the IHS Legislative Affairs staff with other HHS legislative staffs when the IHS has separate congressional appropriations and, therefore, works with separate congressional oversight committees?

The RIW sees some benefits to consolidating IHS Public Affairs with the HHS Public Affairs function. One benefit of consolidation would be enhanced communications support. Another benefit would be improved and routine articulation of Indian health issues by the Department. However, the consolidation could have a negative impact if the Public Affairs staff is absorbed in doing the Department's work and if work products are slowed because more people have to clear the products. In both instances, a primary objective for undertaking these consolidations is to ensure a more cohesive approach to legislation and public information among all the HHS agencies.

4.1 The HHS maintain Legislative and Public Affairs staffs in IHS to ensure that HHS gets timely information from and well-informed analysis about Indian Country.

4.2 The IHS Legislation and Public Affairs staffs must coordinate closely with other HHS agencies in national emergencies and on cross-cutting issues to ensure one voice for HHS.

4.3 The HHS should use performance contracts and inter-agency agreements to ensure accountability to the Secretary.

Consolidation of IHS Human Resources Function with HHS

The RIW was unable to evaluate the consolidation of the IHS human resources (HR) function within HHS because plans are still being formulated. When the plans are available, they will be evaluated and an impact analysis must be performed. The HHS-wide goal is to decrease the number of HR offices to four by the end of FY 2004. The RIW considered this goal, and looking through Indian Country lenses offers the following comments.

- Recruitment and retention of high-quality health care personnel throughout the Indian health care system is critical, especially in remote and isolated areas.
- An assessment of the HR support function within the IHS is appropriate. Proposals must be designed to improve recruitment and retention, and to provide other critical HR support functions in hundreds of health care locations in the Indian health system.
- Consolidating selected HR functions could offer better support and higher levels of expertise.
- With respect to the President's market-based goal, it is worthwhile to consider whether outside sources could better provide certain HR support functions. As with all IHS functions, Tribes would have the first opportunity to contract for services formerly carried out by the agencies.

Additionally, there may be Indian-owned firms able to carry out selected functions under contracts.

- With newer technologies and software, opportunities exist to further automate record-keeping and retrieval and payroll.

The concerns about consolidating IHS HR functions within HHS arise primarily from doubts that multi-agency HR offices will produce the needed results, especially in IHS locations away from IHS Headquarters in Rockville, Md. The IHS mission-critical functions of health care delivery are carried out in hundreds of sites, many in remote, rural locations — very different in structure from the other HHS agencies.

- The IHS work force is composed of front-line health care providers and support staff, and is fundamentally different in character from the work force in most HHS agencies.
- Human Resources functions and practices that work well in other HHS agencies, for example the scientific work force at the National Institute of Health and Centers for Disease Control and Prevention may not work well for a front-line health care delivery work force of 15,000 IHS employees in hundreds of sites in rural, isolated locations in Indian Country.
- The IHS operates under a unique law that applies Indian Preference in hiring and promotion practices. Most of the IHS work force (69 percent) are members of federally recognized Tribes. Their diverse cultures and traditions create a unique work force and work environment.
- The RIW is concerned that the specialized experience and support services relied on by a front-line, community-based health care system would be jeopardized by consolidation into one of the proposed four HR offices.

That Federal agencies become citizen-centered and results-oriented is easy to support. However, the RIW is concerned that the proposed consolidations will not result in an agency more citizen-centered and more results-oriented. Consolidating the HR function at a higher level in the HHS moves away from the front-lines of the Indian health system where the support is needed most. The RIW members doubt that a composite of HR staff from different HHS agencies can ensure the specialized knowledge and skills needed to support the dispersed and remote locations of the IHS work force.

4.4 The IHS should consider realigning Human Resource (HR) support functions within IHS to take advantage of new technologies and enhance HR expertise available to all IHS health care delivery sites in 35 States.

4.5 To preserve the specialized experience and support for the dispersed community-based health care system, the IHS HR functions should not be consolidated with HR functions of highly dissimilar agencies.

4.6 The RIW maintains that many improvements envisioned by the Secretary can be achieved with internal restructuring focused on supporting needs in the front-line health delivery sites.

Consolidation of Indian Health Facilities within HHS

The IHS is one of the few HHS agencies with a direct health care delivery mission; consequently, it has unique health-facility requirements. The IHS facilities' responsibilities, which American Indians and Alaska Natives depend on and which are part of the Federal Trust Responsibility, currently include safe drinking water and sanitation construction as well as the construction and maintenance of hospitals, clinics, health stations, staff quarters, and other

ancillary buildings. These requirements deserve a specific focus connected to the Agency's unique mission.

Tribes, Congress, and the IHS have developed detailed processes for ascertaining facility needs, identifying priorities for health facilities construction, and determining methods for financing the design, construction, and maintenance of such facilities tailored to the unique challenges of the IHS operating environment. Consolidating Indian health facilities management into the HHS health facilities management process would unnecessarily complicate these processes.

The RIW understands the Secretary's concerns focus primarily on federal employee office buildings and facilities. The RIW has no objections to proposals regarding better coordination of federal office space. Basically, the RIW doubts that multi-agency facilities management offices will produce positive results in the more than hundreds of IHS health delivery sites — many of which are in remote, rural locations.

The RIW concerns about consolidating the IHS facilities program within the HHS are related to the IHS hospitals and clinics located throughout Indian Country.

- The consolidation with other HHS agencies will unnecessarily complicate the management of very diverse and dissimilar facilities systems (i.e., the IHS facility construction priority-setting methodology, which is in response to congressional directives, may be compromised).
- Redirection of already scarce and inadequate facilities resources away from the growing backlog of construction and maintenance needs in Indian Country is counter-productive. (Approximately 30,180 Indian homes still lack either or both a safe water supply and adequate sewage disposal system. The IHS has identified a total backlog of 2,902 needed

sanitation facilities construction projects costing $1.6 billion to provide all American Indians and Alaska Natives with safe drinking water and adequate waste disposal facilities in their homes.)

- There is strong opposition in Indian Country to merging the environmental health and facilities programs into the HHS.

4.7 The IHS health care facilities and sanitation construction programs must remain within the IHS. Health facilities require a mission-critical focus to the specific program objectives of the IHS.

4.8 The RIW supports better management of federal office space that does not impact front-line Indian health care facilities.

4.9 The HHS and the IHS should identify in a memorandum of agreement additional steps to ensure full reporting and compliance of IHS facilities data with HHS standards.

4.10 The HHS should acknowledge the relatively higher health facilities needs of Indian Country compared to those of other HHS agencies.

5

VISION FOR THE FUTURE OF INDIAN HEALTH

An important part of the vision for a healthy future for American Indians and Alaska Natives is the elimination of heath disparities they have long experienced. This part of the vision focuses on correcting problems and achieving parity for Indian health by filling in gaps in resources. The second part of the vision goes beyond Indian people having equivalent medical resources and treatment to sustaining health and well-being by living in accordance with Tribal cultural principles and in economically viable communities.

Eliminate Health Disparities

National comparisons of health status show that American Indians and Alaska Natives experience major health disparities compared to the health status of the nation as a whole. The RIW endorses the HHS national goals to reduce the rates of disease and death among American Indian and Alaska Native people to levels that equal rates for other Americans. The RIW urges the HHS and the IHS to aggressively pursue those goals. The RIW urges a special emphasis on disparities that are particularly devastating to American Indians and Alaska Natives. They are:

Diabetes
Unintentional injuries
Suicide and violence
Alcoholism and substance abuse
Life Expectancy

Figure 5.1: Special Emphasis Disparities

The increase in cardiovascular disease is a consideration for future health disparities. The Indian death rates for cardiovascular disease are somewhat elevated compared to the rates for U.S. All Races. Indians died from diseases of the heart in 1994-96 at an age-adjusted rate 13 percent higher than that for the All Races population in 1995, i.e., 156 compared to 138.3. [12]

Common threads link the experience and causes of health disparities among all racial and ethnic minorities. A coordinated approach to address the disparities and those common root causes can be beneficial. However, there are more than 550 Tribes, each with a unique history, culture, and distinctive problems and circumstances. To be successful in eliminating disparities, programs must account for the distinctive problems and circumstances of each Tribe and Indian community. The RIW urges HHS to include Tribal communities in tailoring programs to address their local needs.

Eliminating the health status disparities of American Indians and Alaska Natives partially depends on addressing the disparities in resources and health care services available to them. Theoretically, all members of federally recognized Tribes are eligible for federal health care services. However, what they get is better described as rationed health care. Life-threatening conditions get first priority, and if money is exhausted before the end of the fiscal year, as it often

is, patients with lesser problems find their medical care postponed or simply not available. The gaps in resources and services severely restrict health care services to American Indians and Alaska Natives and are root causes of the failure to eliminate unacceptable rates of death and disease among Indians. Gaps in resources, access to, and use of health care services by Indian people are documented below:

- Only 22 percent of American Indians and Alaska Natives have employer-sponsored health insurance compared to 70 percent of all Americans (one reason is the extremely high unemployment rate on many Indian reservations).
- Forty-two percent of American Indians and Alaska Natives do not have health care insurance.
- The percentage of Indian elders with Medicare benefits (7 percent) is half the rate of other elderly Americans (13 percent).
- Despite having household incomes that are among the lowest, American Indians and Alaska Natives are enrolled in state Medicaid programs at a lower rate (34 percent) than other poor Americans (41 percent).
- The number of physicians per 100,000 population in Indian Country is 73.5 compared to the U.S. average of 229.3.
- The IHS can serve (incompletely) only 1.6 million of the 2.5 million American Indians and Alaska Natives living in the United States identified by the census data.
- The IHS expenditures for personal health care services was approximately $1,775 per capita in 2001 compared to $4,392 per capita for all Americans.
- A 1999 actuarial study found IHS funding per user to be less than 60 percent of the cost of coverage in typical mainstream health plans such as the Federal Employee Health Benefit Plan.

- More than half of IHS and Tribal hospitals and clinics are more than 35 years old. The backlog to correct IHS and Tribal facilities deficiencies is estimated at $1.6 billion.

The RIW vision is to achieve parity in health care services and resources by 2007 and to achieve a quality health care system that effectively meets the needs of Indian people. To achieve this vision, the RIW recommends:

5.1 The IHS funding must be doubled on a per capita basis to bring resources for Indian health in line with those available to other Americans.

5.2 Tribes and urban Indian health organizations must be ensured grant eligibility to access and share in health care resources of other HHS agencies.

5.3 The number of health care providers in the Indian health care system must be doubled.

5.4 Shortages of doctors, dentists, pharmacists, nurses and other health care providers in Indian Country must be eliminated through better recruitment, training, and compensation.

5.5 Aged, inadequate hospitals and ambulatory clinics must be replaced and modernized, and space and equipment sufficiently expanded for a growing Indian population.

5.6 Investments must be made in community infrastructure, especially for safe water supply and waste disposal — forms of municipal infrastructure that are virtually non-existent in remote areas of Indian Country.

The RIW recommendations demonstrate strong support for aggressive action to eliminate the unacceptable health disparities experienced by Indian people. However, the vision for the long-term, sustained health and well-being of Indian

people goes beyond American Indian and Alaska Native having equivalent access to medical resources and treatment.

Sustaining Health and Well-Being

Indian cultural beliefs and traditional Indian medicine arouse curiosity perhaps more than any other aspect of American Indian life. While beliefs, ceremonies, and rituals differ from Tribe to Tribe, many Tribes share an underlying belief that the natural or correct state of all things is harmony. Tribal beliefs, traditions, and customs handed down through many generations play a principal role in individual and collective Indian identity. American Indians and Alaska Natives strive to integrate closely within the family, clan, and Tribe and to live in harmony with the environment. This occurs simultaneously on physical, mental, and spiritual levels. For American Indians and Alaska Natives, wellness is a state of harmony and balance among mind, body, spirit, and environment.

The traditional Tribal healing practices are of great value to Indian patients for restoring and sustaining health and well-being. Many Indian patients and their families consult with Tribal healers or practitioners. The IHS' Traditional Medicine Initiative emphasizes the alliance of traditional and western medical practices between community traditional healers and IHS health care providers. Through this initiative, the IHS seeks to foster formal relationships between local service delivery points and traditional healers so that cultural principles, beliefs, traditional healing practices are respected and affirmed by the IHS as an integral component of the healing process.

The role of traditional Tribal healers is more widely accepted now, especially as Tribal health care programs attempt to address serious health problems such as diabetes, alcoholism and substance abuse, and violence which are not easily remedied by modern medical practice. The role of traditional Tribal healing and

other cultural beliefs and practices is especially important in health promotion because the concept of health for most Tribes is wellness-centered and enforced by social rules of behavior intended to help prevent illness and misfortune. In addition, the Indian health care system recognizes that health is influenced by behaviors. Personal choices in diet, exercise, tobacco use, and alcohol consumption are among the determinants of health and well-being.

One of the objectives in the IHS Strategic Plan is to mobilize American Indians and Alaska Native communities to promote wellness and healing by working with the community to promote healthy behaviors, prevent disease, and create a healthy environment. The expected interim outcome for the objective is improved community involvement in health planning, health promotion and health delivery. Long-term outcomes include increased rates of healthy behaviors, improved health status within communities, decreased rates of chronic disease, and improved life expectancy.

In the preceding section, the RIW endorsed expanded health care programs to eliminate disparities and other health problems. The RIW members have high expectations that full and thorough action to bring necessary resources and attention to the disparities will improve Indian health.

At the same time, some of the most serious health problems afflicting Indian people have deep roots in poverty, cultural dislocation, and unhealthy lifestyles. This is where the vision for sustainable wellness comes in. The well-being of Indian people is founded on the re-enforcement of Tribal cultural principles and practices integrated with an adequately resourced medical system and complemented by viable economic foundations in Tribal communities.

The link between heritage and health is key for sustaining healthy Indian people and communities. Long-term sustainability depends on crafting a health system

by combining the uniqueness of its constituents — the American Indians and Alaska Natives – with the historic obligation of the U.S. Government to Tribes based on treaties and a big-picture approach to health and well-being shaped by Indian principles of family, clan, community, Tribe, and harmony with the environment.

The President's new Faith-Based and Community Initiative supports the approach to sustaining health and well-being by welcoming the participation of faith-based and community-based organizations as valued and essential partners in assisting Americans in need. The independent sector is referred to as a partner to the Federal Government's work. The Initiative identifies faith-based and community caregivers as those who are close to those in need and trusted by those who hurt. Tribal traditional healers fit this description.

Strategies to sustain health and well-being for American Indian and Alaska Native communities include:

- encouraging and supporting traditional Tribal healers, cultural practices and principles;
- emphasizing Indian beliefs, ceremonies, and traditional practices of harmony and health as grounding for individual identity and personal self-worth — especially for young people;
- devoting appropriate resources to wellness and prevention programs targeted to lifestyle including diet, exercise, and the avoidance of risky behaviors;
- recognizing the whole person, extending to family, clan, Tribe, economic, and spiritual elements;
- reinforcing Tribal social values and rules that encourage healthy choices and discourage harmful activities;

- supporting Tribal governance and infrastructure to provide a stable basis for community and individual development;
- building a viable economic base for employment in Indian communities, sustainable income, and means for self-support;
- renewing a healthy environment, in conjunction with other Federal agencies, by correcting environmental damage (toxic waste, dioxins in rivers, etc.) and preserving opportunities for hunting, fishing, and gathering from the land, rivers, and seas much as Indian people have done for thousands of years.

6

A STRUCTURE TO SUPPORT THE VISION FOR HEALTH

This section describes how the future Indian health care system might be structured to support the vision for Indian health.

The ideas for reforming and improving the Indian health system match the following principles in the President's Management Agenda for FY 2002.

> *"The President's vision for government reform is guided by three principles. Government should be:*
>
> - *Citizen-centered, not bureaucracy-centered;*
> - *Results-oriented;*
> - *Market-based, actively promoting rather than stifling innovation through competition."*

The President's three principles provide a useful arrangement for describing options for restructuring the IHS. These principles were applied to the vision for the future of Indian health, as illustrated in the following graphic.

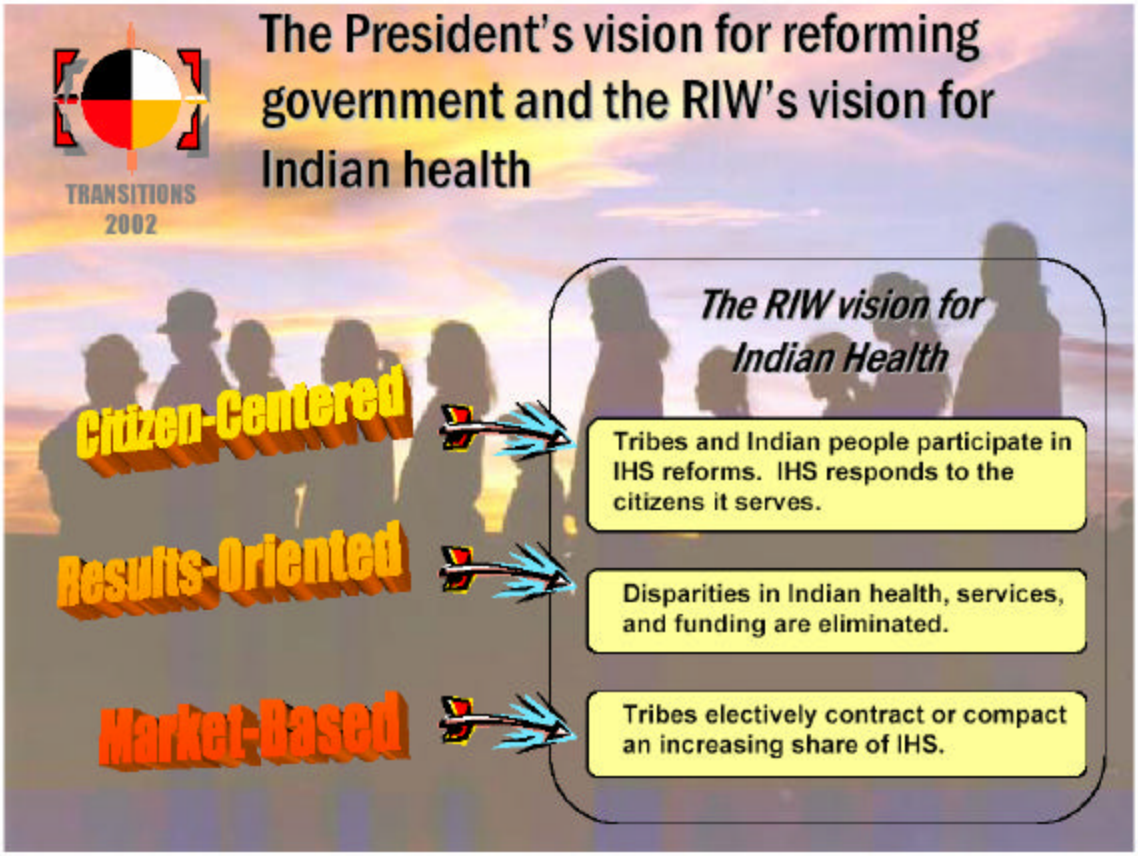

Figure 6.1: Correspondence with the President's Vision

Ideas for a Citizen-Centered IHS

The President's vision for a citizen-centered government matches the IHDT principle that patient care comes first and the RIW's vision whereby Tribes and Indian people participate directly in shaping reforms and policies that affect their health care system. The RIW – a constituent-dominated workgroup – itself demonstrates how IHS facilitates constituent involvement in planning and operating the Indian health care system. The following paragraphs cover key elements of a citizen-centered IHS.

Continuous Consultation

The continuous process of consultation with Tribal Leaders is both the policy of the Federal Government and an effective means for American Indian and Alaska Native citizens to shape and direct the health program to meet their needs. Tribes and Indian people must continue to participate in reviewing all plans and policies that affect the IHS, Tribal, or urban Indian health programs.

Sensitivity and flexibility to cultural principles

Earlier, the vital role of traditional Tribal principles, culture, and heritage in the Indian concept of health was identified. This implies a characteristic not found in mainstream American medical practice — a focus that is unique to Tribal principles. While the Indian health system is a system in terms of many shared features with mainstream American health care systems, it must be flexible in responding to the unique features of many Tribal cultures.

Reaffirmed Indian Health Design Team principles for local control

The RIW reaffirms several IHDT design recommendations that correspond to the principle of a citizen-centered government and recommends:

6.1 The IHS organizational structures must allow flexible approaches to serve diverse Indian communities, traditions, principles and cultures.

6.2 Continue to decentralize, where possible, IHS management and decision making and control to the local level where health care is delivered.

6.3 Health service delivery decisions must occur at the local level and involve Tribal and community participation.

6.4 Shift the roles of IHS Headquarters and Area Offices from directing, controlling, and overseeing front-line programs to supporting them with needed administrative support and technical assistance.

Ideas for a Results-Oriented IHS

The RIW agrees with the President's Management Agenda's focus on improving the performance of the Federal Government. His message:

> *"Government likes to begin things—to declare grand new programs and causes. But good beginnings are not the measure of success. What matters in the end is completion. Performance. Results. Not just making promises, but making good on promises."*

Earlier the RIW recommended doubling the resources for Indian health. Those recommendations outline steps required to get results and make good on promises. The results relate directly to closing gaps in services available to American Indians and Alaska Natives and eliminating disparities in health status. The promises relate directly to the historic obligation of the U.S. Government to Tribes based on treaties. It is not enough that IHS must continually strive for performance improvements in the Indian health care system. Eliminating Indian health disparities is only possible with a substantial expansion of health care resources to American Indians and Alaska Natives.

Indian health surveillance and response

The Indian health care system must detect emerging health problems earlier so that resources and programs can be targeted effectively. Like all Americans, American Indians and Alaska Natives have new concerns about the potentially

devastating effects of bioterrorism and accelerating concerns about communicable diseases that could re-emerge with increasing resistance to antibiotics. American Indian and Alaska Native history includes devastation of whole Tribal populations by communicable diseases. Indian Country is understandably concerned about bioterrorism and the re-emergence of communicable diseases. The RIW supports a coordinated approach to epidemiological surveillance and response for Indian Country in the following areas:

- opportunities to participate in bioterrorism programs and resources;
- participation in the Health Alert Network newly established as part of homeland security measures;
- ways to coordinate with organizations such as VA, CDC and State health departments;
- concentrated tracking and attention on health issues and diseases of the American Indian and Alaska Native populations; and
- disease surveillance and response tailored to the unique environmental and cultural factors of Tribal communities.

Invest in information technology and an Indian Health Network

The RIW reviewed a five-year plan to invest in information technology (IT) and to connect all local IHS, Tribal, and urban Indian health sites through an Indian Health Network. More importantly, the RIW envisions communications technology linking all Indian hospitals and health centers throughout the United States. A modernized nationwide network offers a way to integrate operations, and to access support services and assistance, and share capacities from any site in the United States. In such a network, providers and supporting staff can

access support and assistance from anywhere in the network. The historic constraints on progress resulting from geographic remoteness and the inefficiencies of dispersed small-scale operations would diminish as sites work together to increase buying power and lower costs. The emerging telemedicine and distance learning technologies are ideal for health care sites located in remote areas that often experience harsh weather conditions. The possibility of leveraging marketplace clout through the collaboration of hundreds of sites while maintaining local flexibility and independence is worth further exploration.

The RIW reviewed and supported the Information Technology Vision and Actions for 2007 and considers it a companion document to this preliminary report. Other IHS workgroups will be asked to explore detailed IT options over the next few months and the final RIW report may offer more recommendations in addition to the following:

6.5 Triple investment in information and communications technology over the next five years.

6.6 Create an interconnected Indian Health Network for hundreds of widely dispersed health care sites to more effectively collaborate and pool information, expertise, and resources.

6.7 Standardize data systems and protocols be standardized to assure all locations work together using common standards for communication and interoperability.

6.8 Specify hardware and software standards to assure all sites maintain compatibility while preserving flexibility to select differing hardware.

6.9 Utilize compatible information systems developed in the much larger, better funded federal health care systems such as Department of Defense and Department of Veterans Affairs.

6.10 Develop a national data warehouse where consolidated data is retrievable from all sites throughout the Indian Health Network.

Collaboration and Access to Resources

Many ideas have been identified for collaborating with other public and private sector organizations to access additional resources for Indian health and improve performance. The following are some recommendations to be examined in more detail:

6.11 Expand efforts and remove barriers for the IHS to work with other HHS agencies.

6.12 Tribal eligibility for grants must be obtained across the HHS and other Federal Departments, especially for newly created programs for homeland security and bioterrorism.

6.13 Remove barriers (Title XIX) that prevent Tribes from contracting directly (51st State concept).

6.14 Assess additional roles for the IHS in the area of environmental health, e.g., hazardous and nuclear waste and water quality.

6.15 Address provision of technical support and funding for newly recognized Tribes.

6.16 Improve the IHS/HHS/OMB budget process to allow for better access and follow-up by Tribes.

6.17 Expand third-party billing capabilities at all sites in the Indian health care system.

Continue taking advantage of emerging business practices

The Business Plan Workgroup is examining a variety of emerging business practices to improve performance, economize on costs, maximize collections and render support services to front-line health providers. The Business Plan Workgroup, 25 individuals who are Tribal Leaders, IHS officials, and

representatives of urban Indian health programs and national Indian health organizations, is charged to recommend a business plan for enhancing the level of patient care for American Indian and Alaska Native people over the next 5 years. The Business Plan Workgroup is updating and refining the IHS Business Plan and will submit the draft plan to American Indians and Alaska Natives to seek their input in the plan. In updating and refining the IHS Business Plan, the Business Plan Workgroup will explore how the Indian health care system can improve its business practices to address current and emerging issues over the next five years. The RIW and the Business Plan Workgroup have scheduled joint meetings to consider how some of these practices could be included in long-range restructuring.

Taking the next steps toward Centers of Excellence

The IHDT originally considered the expanded use of Centers of Excellence. Centers of Excellence would partially consolidate dispersed and inadequate support functions from Area Offices into one-to-three existing offices that have exceptional reputations for quality support. It is time to take the next steps expanding IHS' implementation of Centers of Excellence first recommended in the IHDT report in 1996.

Since 1997 some progress has been made through sharing agreements among Area Offices. In the future, it is possible that administrative and technical assistance functions provide customer-focused support and decreased emphasis on historical administrative territories. Utilizing the communications capabilities of an Indian Health Network, high quality support could be offered anywhere in Indian Country. Quality support services flexibly tailored to the specific needs of each IHS, Tribal, or urban program can be provided cost-effectively by one-to-three support centers. Many services can be performed either with Federal

employees or Tribal contractors depending on function, cost, and Tribal choice. More detailed recommendations and plans for Centers of Excellence will be included in the RIW's final report, including the analysis of the benefits, costs, and savings resulting from developing Centers of Excellence that could be reinvested to patient care resources.

Assess realigning Human Resources, Contracting/Grants, and Financial Management support functions

The IHS should assess the feasibility of realign certain operational support functions. This assessment will include the benefits, costs, and savings that could be reinvested in expanded health care services for Indian patients. Some administrative support services can be provided better, faster, and cheaper than is possible under the existing configuration. No internal restructuring option that preserves resources for the Indian health system and offers the probable benefits of increased efficiency and support to front-line health care will be ruled out. The RIW recommends an analysis be conducted and implementation plans be developed for the following areas:

A: Human Resources

- Consider placing human resources operational support functions in one-to-three sites or to maintain the existing decentralized structure.
- Develop Government Performance Results Act (GPRA) benchmarks for administrative support functions (HR functions).
- Improve the current HR process to become more efficient and responsive.
- Explore ways to empower local service units to expand their performance of HR functions.

- Expand scholarship programs to begin to assure an optimum supply of health professionals to the IHS, Tribes, Tribal organizations, and urban Indian organizations involved in the provision of health service to Indian people.

B: Financial Management

- Consider placing financial and accounting operational support functions in one-to-three sites or to maintain the existing decentralized structure.
- Explore how the HHS initiative for financial management can improve financial information for the IHS and Tribes.
- Assess the emerging benefits of communications and technology for financial management functions.

C: Contracts, Grants, Acquisitions

- Consider placing contracting, grants, and acquisitions operational support functions in one-to-three sites or to maintain the existing decentralized structure.
- Assess the emerging benefits of communications and technology for contracts, grants, and acquisitions.

Ideas for Market-Based IHS

The IHS practices and the President's goal for a market-based government both relate to an increase in the outsourcing of IHS programs and services. More than half of the IHS budget goes to contracts and compacts with Tribal Governments for operating their own health programs. Tribes can operate their programs with greater flexibility and innovation than the IHS can. In addition to outsourcing programs to Tribal Governments, the IHS purchases supplemental health care services from the private sector for services that are unavailable from

the IHS or impractical for the IHS to deliver directly. Approximately 15 percent of the IHS budget goes to purchasing these services. The RIW notes that in FY 2001 $484 million was collected or reimbursed from third parties for IHS patients who are covered by Medicare, Medicaid, and private insurance — which is another way of gaining resources from outside the Agency to supplement IHS appropriations.

Although trends for Tribal contracting for Indian health care programs parallel the market-based goal, we also find distinctions unique to operating Federal health programs for American Indians and Alaska Natives. One distinction is the right to self-determination ensured by numerous Federal laws. The Indian Self-Determination Act grants Tribes the right to operate their own health care programs. Some Tribes have expressed their intention to retain a federally-operated health care program therefore not all IHS programs are expected to be outsourced to Tribes. A second distinction relates to the buy-Indian law affording preference to Indian-owned firms when the IHS acquires goods and services from private sector sources. Both distinctions shape market-based activities for the IHS.

Maintain Tribal Self-Determination Rights

The RIW strongly supports Tribal self-determination rights, whether expressed by entering into a compact and/or contract for IHS programs or by retaining federally provided health care services from the IHS. Planning and negotiating contracts/compacts between Tribes and the IHS is a mature process. Tribes maintain the right to make informed decisions in operating their programs and the provision of information by the IHS to the Tribes is necessary to support the process of good decision-making.

6.18 All organizational reforms within IHS must support and accommodate Tribal rights to compact, contract, or retain IHS to operate health programs directly.

6.19 The IHS must track resources that are realigned to ensure that Tribal shares for which each Tribe is eligible are not reduced as consequence of reforms and restructuring, any shares re-allocated not lose identity as Tribal shares, and any savings resulting from restructuring be applied to programs delivered directly by the IHS, by Tribes through compacts or contracts, and by the urban Indian health programs (I/T/Us).

Organizational reforms relating to self-governance, self-determination, direct care, and urban Indian health

The IHS has organizational units specializing in working with and supporting Tribes. These units are: 1) the Office of Tribal Self-Governance which specializes in self-governance compacts; 2) the Office of Tribal Programs which specializes in self-determination contracts and more generally as liaison with Tribes; 3) a mixture of offices which specialize in IHS direct care programs; and 4) the Urban Indian Health Program.

Within the next five years, an estimated 75 Tribes are likely to enter into compacts and 50 Tribes are likely to enter into contracts to operate IHS programs. The RIW recommends:

6.20 Conduct assessments of the Office of Tribal Programs, IHS direct programs, and the IHS Urban Indian Health Program to complement the assessment by the Office of Tribal Self-Governance.

6.21 The extent and type of restructuring of these offices must be in accordance with the extent of compacting, contracting, direct, and urban Indian health programs.

6.22 Develop contingency plans to minimize disruptions in delivery of health care services in the event a Tribal contract or compact is retroceded.

6.23 The IHS must carefully manage large transfers of Tribal shares to ensure a smooth and orderly transition of programs, activities, functions, and services to Tribes. The magnitude of the transfers is one of the reasons that further Federal FTE cuts for IHS should be reviewed with caution.

Technical Assistance to Contracts and Compacts

After Tribal contractors and compactors assume operation of their health programs, most continue to seek some technical assistance and professional support services from the IHS. Restructuring plans for the IHS and continued outsourcing to Tribes must ensure that this assistance and support will be maintained. Not all technical support has to come from traditional sources such as the IHS Area Offices. In the vision for an integrated Indian Health Network, professional services and related technical assistance could be supplied from Centers of Excellence, Tribes, Tribal organizations, or Indian-owned and other specialty firms contracting with the network.

Funding transition and support costs

Some Tribes are reluctant to contract or compact IHS programs because of the additional costs for management and overhead incurred with the operation of the programs. The Indian Self-Determination Act authorizes payment for costs that a Tribal contractor/compactor incurs in addition to the transferred program resources. Contract support costs are currently funded at 86.54 percent of the

total need. This is one reason that contracting has slowed in recent years. The impediment for additional Tribal contracting and compacting can be removed by fully funding contract support costs and other one-time costs of transferring program resources.

6.24 The impediment for additional Tribal contracting and compacting can be removed by fully funding contract support costs and other one-time costs of transition.

Support Services in a Mixed Environment

Many Tribes continue to support the existence of all twelve Area Offices. Area Offices are points of access to the Federal Government. Over time, Area Offices could diminish in size and scope, and business and administrative support services may gradually evolve away from Area Offices and become available through the Indian Health Network. The opportunity to realize cost savings with a shared source of business and administrative services will be important to Tribes experiencing higher costs in carrying out functions in smaller organizations located remote areas. For instance, some Tribes may elect to form Tribally-chartered organizations to develop economies of scale and provide necessary support services more economically than is possible for many Tribes to do themselves.

6.25 The IHS should support efforts by Tribes to form Tribally-chartered organizations to offer business and administrative support services.

6.26 Tribes should be consulted about the benefits and costs of a range of approaches to reform engineering services.

A Supplement to Follow

The HHS restructuring plans were incomplete and unavailable at the time of this preliminary report. When they become available, the RIW will analyze them to develop additional restructuring options. The RIW is especially interested in ideas from Indian Country about long-range recommendations in Chapter 6.

6.27 The RIW recommends holding at least one additional meeting to consider and incorporate feedback from Indian Country, and to refine long-range plans for reforming the Indian health care system.

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